A-7

STATE OF FLORIDA

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO.: 2009-24503**

FERNANDO MENDEZ-VILLAMIL, M.D.,

RESPONDENT.

_____/

ADMINISTRATIVE COMPLAINT

Petitioner, the Department of Health, by and through its undersigned counsel, files this Administrative Complaint before the Board of Medicine against Respondent, Fernando Mendez-Villamil, M.D., and in support alleges:

1. Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this complaint, Respondent was a licensed physician within the State of Florida, having been issued license number ME 75685 but was not board certified in Psychiatry.

3. Respondent's address of record is 1898 SW 22nd Street, Suite B Miami, Florida, 33145.

4. At all times material hereto, Respondent, while practicing medicine in the State of Florida, treated three (3) patients for psychiatric conditions, they are referred to throughout by their initials as AT, FB, and WS.

5. At all times material hereto, Respondent prescribed to these three (3) patients one or more of the following controlled substances; Xanax, Zyprexa, Abilify, Seroquel, Depakote, Provigil, Actiq, Adderall, Soma, Restoril, Risperdal, Zyprexa, and Depakote.

6. The above mentioned controlled substances are more particularly defined as follows;

a) Dextroamphetamine (Brand name Adderall) is used as part of a treatment program to control symptoms of attention deficit hyperactivity disorder (ADHD; more difficulty focusing, controlling actions, and remaining still or quiet than other people who are the same age) in adults and

children. According to Section 893.03(4), Florida Statutes, amphetamine is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of the substance may lead to severe psychological or physical dependence;

b) Xanax (alprazolam) is an anti-anxiety agent benzodiazepine, used primarily for short-term relief of mild to moderate anxiety and nervous tension and is a schedule IV legend drug controlled pursuant to Chapter 893.03, Florida Statutes and has a low potential for abuse which may lead to limited physical or psychological dependence and has a currently accepted medical use in treatment in the United States;

c) Risperdal (risperidone) an antipsychotic agent, which may act by a combination of dopamine and serotonin antagonism;

d) Zyprexa (olanzapine) - A drug used to treat certain mental disorders. It is a type of antipsychotic and a type of monoamine antagonist;

e) Depakote, known as Valproic acid is used alone or with other medications to treat certain types of seizures. Valproic acid is also used to

treat mania (episodes of frenzied, abnormally excited mood) in people with bipolar disorder;

f) Adderall is the combination of dextroamphetamine and amphetamine and it is used as part of a treatment program to control symptoms of attention deficit hyperactivity disorder (ADHD). According to Section 893.03(4), Florida Statutes, amphetamine is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of the substance may lead to severe psychological or physical dependence;

g) Ativan, known as Lorazepam is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation. Lorazepam comes as a tablet and concentrate (liquid) to take by mouth. According to Section 893.03(4), Florida Statutes, Lorazepam is a Schedule IV controlled substance and has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III;

h) Restoril, known as Temazepam is used on a short-term basis to treat insomnia (difficulty falling asleep or staying asleep). Temazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow sleep. According to Section 893.03(4), Florida Statutes, Temazepam is a Schedule IV controlled substance and has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III;

i) Valium is the brand name for diazepam and is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes (2010), diazepam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently 4 accepted medical use in treatment in the United States. Abuse of diazepam may lead to limited physical or psychological dependence relative to the substances in Schedule III;

j) Zoloft (sertraline hydrochloride) is a medication used in treating a variety of mental health disorders including social anxiety disorder (SAD);

k) Lexapro (escitalopram oxalate) is a selective serotonin reuptake inhibitor (SSRI) proven effective in the treatment of depression and generalized anxiety disorder (GAD);

l) Pexeva, known as paxil is indicated for the treatment of obsessions and compulsions in patients with OCD.

FACTS SPECIFIC TO PATIENT AT

7. Respondent treated AT from April 2005 through September 2010, (the treatment period); AT was 3 years old when he began treatment and Respondent's working diagnoses was ADHD (attention deficit hyperactivity disorder) and ruled out mental retardation.

8. In terms of Respondent's diagnosis, the following matters were noteworthy;

a) There is no documentation that AT was ever referred for an evaluation for mental retardation;

b) In terms of the ADHD diagnosis, there is nothing in the notes that shows that Respondent assessed this with any criteria;

c) Though Respondent's medical record of his initial evaluation dated April 13, 2005 documented AT's affect as being "hyperactive", affect

is the outward demonstration of one's emotions and is not the definition of hyperactive used to diagnose ADHD;

d) There is no supporting documentation in the medical record to justify the diagnosis of hyperactivity.

9. During the remainder of the treatment period, Respondent continued to prescribe to AT multiple prescriptions of one or more of the above mentioned controlled substances in excessive and/or inappropriate quantities and/or combinations and Respondent's medical records fail to justify prescribing the amount, frequency, and or combination of the prescriptions issued.

10. During the treatment period, anomalies in Respondent's medical records were discovered including but not limited to the following;

a) In the note on October 20, 2007, Respondent prescribed the patient Abilify for impulsivity. Respondent documents that the patient's insight and judgment are good. Respondent also documents that this now 5 year old is able to take care of himself. In light of the foregoing there is no basis to change the medication. In light of the foregoing the medical record also does not justify the prescription of an antipsychotic medication

for symptoms of ADHD when the prescription of a stimulant was indicated to treat the condition.

b) On the progress note dated October 7, 2008, Respondent gives the patient (AT) a Global Assessment of Functioning (GAF) which is a scale used to assess psychiatric status, ranging from 1 (lowest level of functioning) to 100 (highest level), measuring psychologic, social, and occupational functioning. It is widely used in studies of treatment effectiveness of 58. Respondent documents that the patient is able to care for himself and that he has good insight and judgment;

c) In the notes dated August 2009 through October 2009, Respondent documents the GAF as going from 63 to 44. Respondent failed to provide any basis for this significant change in the patient's chart considering that this supposed to change happened comparatively quickly over a mere two months time;

d) Respondent documented in the patient record on the note of August 4, 2009 that the GAF was actually initially documented as 0. It was then changed to 63 without explanation and the Global Assessment of Functioning was whited out;

e) In the note dated October 6, 2009, Respondent notes that the patient has "aggressive behavior." There is no basis or justification for Respondent's subsequent note in the chart will when Respondent documents that the patient's insight and judgment are good and that he is now able to care for himself;

f) Per prescriptions in the record, patient AT was on up to 3 different medications (an antipsychotic, an antihypertensive, a stimulant and an antihistamine) prescribed by the Respondent at any given time.

FACTS SPECIFIC TO PATIENT FB

11. Respondent's initial evaluation of patient FB occurred on October 17, 2002 whereupon he diagnosed FB with schizophrenia of the paranoid type.

12. Over the course of his treatment, FB was placed on multiple antipsychotics, antidepressants, and sedative hypnotic medications.

13. FB's medical records reflect on multiple occasions different handwriting in the chart notes even on the same day and notes are inscribed with different pens.

14. There is no medical justification in patient FB's medical records for the timing of his visits with Respondent nor justification for the choice of medications, given the symptoms they were prescribed to treat.

15. The GAF in FB's chart has been whited out and changed from zero with a slash through it (meaning that it cannot be assessed) to 40 without any the change being made.

16. On the progress note dated December 26, 2006 Respondent documented that the patient is "stable on medications" though is "somewhat depressed D/C (discontinued) Zoloft start Lexapro", on this date the GAF nod at 40 (serious symptoms) and Respondent notes that the patient is to come back in two months; no reason is given in the record for such a delay in seeing the patient given his current condition or why despite the fact that he was currently "stable" that the medication was changed.

17. Despite Respondent having prescribed patient FB drugs over the previous five years that have known side effects such as diabetes, it is only belatedly on April 10, 2007 that Respondent first documents asking the patient about side effects of diabetes such as thirst, frequency of urination, and weight gain.

18. Respondent inappropriately waited to explore the potential onset of diabetes by only charting his first inquiry on this subject in April 10, 2007.

19. Respondent's progress note of June 16, 2007 states that he will "treat patient with atypicals to avoid NMS TD EPS so clearly related to typicals". This note appears to be out of place and not part of the actual medical record in that the patient has been prescribed atypicals for the last five years. There is nothing in the medical record to justify such a belated note without laboratory test results or other diagnoses supporting that position.

20. On June 16, 2007, Respondent changed FB's medication to Pexeva, an antidepressant, without any medical justification in the record for Respondent's prescription of the atypical antipsychotic medication.

21. Despite the fact that Respondent's progress note dated January 08, 2008 has FB with a GAF score that has decreased to 36 (implying treatment failure and/or symptomatology increasing) Respondent's treatment plan is to "continue present treatment. Referral to day treatment program".

22. There is no medical justification for two countervailing treatment plans to be contained in the same sentence for the same time.

23. Given the circumstances there is no medical justification for sending an actively psychotic and decompensating patient for participation in a day treatment program with the expectation of any therapeutic gain arising.

24. Respondent's notes in FB's chart that while the patient is very depressed and experiencing auditory hallucinations and failing to function even at a baseline that the patient still possesses good insight and judgment and is stable on medications. This annotation is internally contradicted and makes no sense. Similarly of note is the fact that in the note where Respondent documents whether or not the patient is able to care for himself Respondent has circled "yes" and "no".

25. On the progress note dated June 16, 2007, there are obviously different pens used in this note. The first note states that the patient is stable on meds, but the note inscribed with a different pen states that he is not stable and the medications need to change.

Additionally, the GAF was decreased to 35. At the end of the note which is where the plan is, it's documented as saying "continue present treatment." Again there are so many inconsistencies in this note, which is again just a reflection of the entire chart.

26. The progress note dated April 30, 2008, documents that per the PCP, there are no lab changes, however, that statement is not documented on the lab sheet that he has kept in the patient's chart.

27. Per prescriptions in the record, patient FB was on 4 different medications (an antidepressant, 2 sedative hypnotics, and an antipsychotic) prescribed by the Respondent at any given time.

28. Respondent's sworn deposition testimony stated that, FB has had multiple medication changes though Respondent said that the patient was stable. Respondent also documents that there are no labs and no weights but that he obtained this information, from his patient who was diagnosed as psychotic. Given FB's clearly documented problem with verbalization, he was also an inappropriate candidate for the group therapy prescribed for him by Respondent.

29. In the Patient Sign-In sheets for FB, the following anomalies exist suggesting that the medical records are entered after the event or

were entered with an improper purpose for one or more of the following reasons;

a) June 5, 2010, it is documented that Respondent saw the patient in evaluation from 11:00 am to 11:15 am. Although, the patient didn't sign in until 11:05 am;

b) August 13, 2009, it is documented that FB must have signed in before 1:00pm in the afternoon and 10:15 am in the morning, however, his progress note documents that he was seen in treatment from 2:10 pm - 2:20 pm in the afternoon;

c) April 29, 2009, it is documented that FB was seen in treatment from 10 a.m. to 10:10 a.m. However, the patients that signed in before him were signing in at 6 o'clock and 7 o'clock either in the morning or in the evening;

d) September 3, 2008, it is documented that FB had signed in some time after 6:30. However, it is documented in his progress note on that day that his appointment was from 5:00 pm to 5:10 pm.

FACTS SPECIFIC TO PATIENT WS

30. Upon review of the chart, the initial evaluation of patient WS was done on February 19, 1999, and the documentation shows

thereafter that patient WS was seen evaluated in 15 minute sessions.

31. The diagnoses listed are schizophrenia, paranoid type, and moderate mental retardation.

32. Upon review of WS's medical records, there are eleven instances where either the medical records, do not justify the course of treatment, have been altered after the event, were inaccurately entered or were entered for fraudulent purposes as noted below.

33. On the progress note dated August 21, 2009, it is documented that the patient's insight and judgment are good, though at the same time it also documents, "not sleeping. Hit one of the staff, verbally abusive... group home placement." Respondent also documents that WS is able to care for himself yet he is in group home placement.

34. On the progress note dated July 6, 2007, it is documented, "stable on meds, continue present meds." But then there is a change in different ink on that note as well as the GAF being changed.

35. On the progress note dated January 4, 2008, it documents, "per PCP, no lab abnormalities secondary to psychotropics." However, this date is not documented on the sheet that Respondent documented the weights and the labs.

36. Per prescriptions in the record, WS was on 5 different medications (an anticonvulsant, a sedative hypnotic, 2 antipsychotics, and an antihistamine) prescribed by Respondent at any given time.

37. Respondent admitted in sworn deposition testimony regarding WS, it is documented that WS had mental retardation and schizophrenia.

38. Respondent also reports that he got records from a previous provider but did not keep a copy in the chart. The standard of care requires that once records are obtained from previous providers, they are placed in the chart.

39. Respondent has testified, in deposition, that although Respondent ordered a Depakote level per his report, there is no Depakote level in the chart. He states that it is not in the chart because the patients don't bring in the blood work.

40. Conventional routine practices is for the lab to send a copy via fax and/or via mail to the office of the physician that ordered the test.

41. Later, Respondent states, in the deposition, that how he got the Depakote level of 68 was likely because the WS's mother told him that was the level.

42. A physician cannot make treatment decisions and rely on lab results reported by the patient or the patient's caregiver. Doing so is a breach of the standard of care absent the actual test results.

43. Additionally, it is documented that WS was admitted to the hospital. Respondent says that he was the person that admitted WS to the hospital and implies that he did see the patient while in the hospital.

44. However, there is no documentation in the chart that he actually saw WS while in the hospital. Once a patient is seen in the hospital, typically Respondent will get the records from the hospital so that way, the care can be documented in the medical chart.

45. On the Patient Sign-In sheets for WS, there are no actual arrival times documented on this patient's sign-in sheet in order to

confirm or deny when the patient actually attended the appointments.

COUNT ONE

46. Petitioner reincorporates and realleges paragraphs 1 through 45 as if fully set forth herein.

47. Section 458.331(1)(t), Florida Statutes (2006, 2007, 2008, and 2009), provides that the gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances is grounds for discipline by the Board of Medicine.

48. Respondent failed to practice medicine with that level of care, skill and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances in treating Patient AT, in one or more of the following ways:

a) By failing to refer patient AT a board-certified psychiatrist as well as a neurologist so that he could be evaluated for mental retardation;

b) By prescribing Abilify on October 20, 2007 for impulsivity, an antipsychotic for symptoms of ADHD instead of a stimulant which would have been indicated for that illness;

c) By failing to appropriately and timely obtain lab testing given the medications that the Respondent was prescribing this patient;

d) By failing to refer the patient to a board-certified psychiatrist for evaluation especially in light of the medications being prescribed;

49. Respondent failed to practice medicine with that level of care, skill and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances in the treatment of patient FB in one or more of the following ways:

a) By inappropriately waiting until April 10, 2007 to first ask and document in the file whether the patient had been suffering any symptoms of diabetes such as, weight gain, thirst and/or frequency in urination despite the fact that Respondent had been prescribing several medications with diabetes as a known potential side effect in the preceding five years;

b) By inappropriately deciding in January 2008 to treat the patient by referral to a day treatment program despite the fact that the patient was actively psychotic and decompensating;

c) By failing to appropriately and timely obtain lab testing given the medications that Respondent was prescribing this patient;

d) By inappropriately prescribing two different antidepressants medications together with two sedative hypnotic medications while also prescribing an antipsychotic medication;

e) By failing to refer the patient to a board-certified psychiatrist for evaluation especially in light of the medications being prescribed;

50. Respondent failed to practice medicine with that level of care, skill and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances in the treatment of patient WS in one or more of the following ways:

a) By inappropriately prescribing an anti-convulsant, a sedative hypnotic, and two antipsychotic medications;

b) By failing to refer the patient to a board-certified psychiatrist for evaluation especially in light of the medications being prescribed;

c) By failing to appropriately and timely obtain lab testing given the medications that the Respondent was prescribing this patient;

51. Based on the foregoing, Respondent has violated Section 458.331(1) (t), Florida Statutes (2006, 2007, 2008, and 2009).

COUNT TWO

52. Petitioner reincorporates and realleges paragraphs 1 through 45 as if fully set forth herein.

53. Section 458.331(1)(m), Florida Statutes (2006, 2007, 2008 and 2009), subjects a licensee to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

54. During the treatment period, Respondent's medical records for AT's, FB's, and WS's course of treatment failed to justify one or more of the following;

a) The presence of one or more recognized medical indications for the use of a controlled substance;

b) The extent of controlled substances being prescribed;

c) An appropriate diagnoses to warrant the prescriptions that were written;

d) The basis for changing various medications.

55. During the treatment period Respondent failed to maintain medical records pursuant to the requirements of 458.331(1)(m), Florida Statute in that they;

a) Were inappropriately deleted or amended after the fact;

b) Maintaining or inappropriately reflected amended, altered or invented facts such as GAF scores and/or lab results;

c) Inaccurately reflect date and times of the patient's visits;

d) Are internally inconsistent and/or contradictory.

56. Based on the foregoing, Respondent has violated Section 458.331(1) (m), Florida Statutes (2006, 2007, 2008, and 2009).

COUNT THREE

57. Petitioner reincorporates and realleges paragraphs 1 through 45 as if fully set forth herein.

58. Section 458.331(1)(q), Florida Statutes (2006, 2007, 2008 and 2009), provides as follows: prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance,

other than in the course of the physician's professional practice is grounds for discipline by the Board of Medicine. For purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his intent.

59. During the treatment period, Respondent prescribed controlled and/or legend substances to patients AF, FB, and WS in the quantities and combinations described inappropriately and or in excessive or inappropriate quantities and or combinations.

60. Based on the foregoing, Respondent has violated Section 458.331(1) (q), Florida Statutes (2006, 2007, 2008 and 2009).

WHEREFORE, the Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of

Fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 11th day of January, 2013.

JOHN H. ARMSTRONG, MD
State Surgeon General and
Secretary of Health

Robert A. Milne
Assistant General Counsel
Florida Bar # 622338
DOH Prosecution Services Unit
4052 Bald Cypress Way-Bin C-65
Tallahassee, Florida 32399-3265
(850) 245-4640 Office
(850) 245-4681 Facsimile

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Angel Sanders
DATE JAN 14 2013

RAM/sdw

PCP Members: Dr. Avila, Dr. Nuss
PCP: 01-11-13

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or his behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.